Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL25455003M
Compliance #: HL25455004C

Date Concluded: March 22, 2022

Name, Address, and County of Licensee Investigated:
Heritage Haven INC
3044 Morris Thomas Road
Duluth, MN 55811
St. Louis County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Jana Wegener, RN Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged the resident was neglected when the alleged perpetrator (AP), facility staff, failed to transfer the resident according to the resident's individual assessed needs. The resident fell and sustained multiple injuries including a left hip fracture.

Investigative Findings and Conclusion:
Neglect is substantiated. The AP and the facility were responsible for the maltreatment. Six days prior to the fall the resident was admitted to hospice for end-of-life care and required increased assistance with transfers. The facility did not update the residents plan of care to ensure all staff were aware of the residents need for increased assistance of two staff with transfers. The resident was assisted by one staff to transfer to the bathroom, became weak, and fell. The resident broke her hip.

The AP was responsible for the maltreatment. The residents plan of care directed staff to provide assistance with transfers and ambulation using a gait belt, walker, and one staff

assistance. The AP stated she was aware the resident needed a gait belt for transfers; however, the AP did not use a gait belt to assist the resident to transfer to the bathroom. The resident became weak and had an uncontrolled fall onto her knees. The resident sustained multiple injuries including a left hip fracture.

The investigation included interviews with facility staff members, including leadership staff, nursing staff, and unlicensed staff. The resident's medical records, employee records, incident reports, photographs of the residents' injuries following the fall, and facility policy and procedures were reviewed. In addition, the facility medication administration system was reviewed including narcotic administration, tracking, and medication destruction.

The resident was admitted to the facility with diagnoses including stage five chronic kidney disease, dementia without behavioral disturbances, legally blind, abnormal posture, difficulty walking, muscle weakness, mild cognitive impairment, and a history of falls prior to admission.

The resident's admission assessment indicated the resident was oriented to person and time and was able to walk short distances up to 25 feet. The resident required active assistance of one staff and a gait belt using a walker or wheelchair for ambulation and mobility.

The resident's Fall Risk Assessment and Fall Plan of Care indicated the resident was at a risk for falls due to incontinence, poor vision, balance problems while standing and walking, decreased motor coordination, and a history of falls. The resident was able to walk short distances with staff assistance, a walker, and a gait belt.

The residents Treatment Administration Record (TAR) included physician orders for the resident to use a gait belt and a walker for all transfers and ambulation. The TAR included signed daily documentation from morning, evening, and night shift until the resident's death which indicated staff documented the resident was assisted with transfers by one staff using a gait belt and walker.

The resident's medical record was reviewed and there was no documentation the resident ever refused a gait belt during transfers or ambulation.

Approximately six weeks after admission to the facility the resident was admitted to hospice with end stage renal disease which caused increased weakness, and difficulty breathing.

The residents' hospice start of care assessment indicated the resident was at risk for falls, was chair or bedfast, her ability to walk was severely impaired, limited, or non-existent; and indicated she could not bear her own weight and must be assisted.

The resident's hospice admission documentation included a provider note that indicated the resident had a terminal diagnosis of end stage renal disease. The provider note indicated the

resident became short of breath at rest and with conversation, was no longer ambulatory, but could transfer with assistance of two staff.

A hospice nurses note from the day of admission indicated the resident was having increased shortness of breath, weakness with an increased respiratory rate at rest, and increased shortness of breath with conversation. The note indicated the resident was no longer able to ambulate and could only transfer to a chair or wheelchair with two-person assistance.

The hospice facility documentation indicated hospice nursing communicated the residents increase care needs to the facility nursing staff which included the residents need for assistance from two staff with transfers.

Six days after admission to hospice, a facility incident report indicated the AP was walking the resident to the bathroom when the resident became weak and stated she could not walk anymore. The incident report indicated the AP put both arms around the resident's waist, lowered the resident to the floor, and placed the resident on her side. The facility investigation indicated the AP was not using a gait belt when ambulating the resident to the bathroom at the time of the incident.

When interviewed a staff member stated the day of the incident the resident reported the AP had "dropped her". The staff stated the resident had multiple injuries, was not ambulatory when getting up for breakfast, and had more pain than usual. The staff stated the resident always required the use of a gait belt and a walker with transfers because she would get weak, fatigued, and unsteady with ambulation. The staff stated the resident never refused use of the gait belt. Staff stated any resident requiring active assistance from staff with transfers or ambulation required a gait belt.

The hospice registered nurse (RN) stated when she arrived at the facility the day of the incident to do a post fall assessment, the resident was resting in her chair. The nurse stated she lightly touched the resident who woke and began yelling "JABBING, JABBING, JABBING"! The hospice RN stated the resident told her staff threw her on the ground and left her lay there. The hospice RN stated the resident had multiple bruises and skin tears, a large baseball sized hematoma on her right knee, large skin tears on her left elbow, and skin tears on her right and left knees with the skin pulled together with steri-strips. The hospice RN stated the resident's injuries did not appear consistent with being gently lowered to the ground.

In a post fall nursing progress note the facility registered nurse documented the provider was updated and orders were received for imaging of the resident's hip and knee.

The resident's family member stated when the AP entered the resident room to assist the resident to transfer into bed for the x-ray to be taken, the resident appeared afraid of the AP and leaned back in her chair and pulled away from the AP and yelled, "No, no" and stated the AP was the one who dropped her. The family member stated at that time the AP transferred

the resident from her wheelchair to the bed by placing her arms under the resident's arms and hoisted the resident into bed, but no gait belt was used.

The radiology report indicated the resident had an acute impact left femoral neck hip fracture.

Another Hospice RN stated she was onsite the day after the incident and was told the residents injuries happened because of the fall and the AP did not have a gait belt on the resident as directed. The hospice RN stated the resident's injuries were "horrifying" and did not appear consistent with being gently lowered to the floor but appeared to have been caused by "a dramatic impact to the floor". The RN indicated the resident had "a catastrophic fall with injuries" and was "actively dying".

When interviewed the AP stated she initially reported to the facility when the resident started to fall, she lowered the resident to the floor. The AP clarified when the resident started falling forward, she grabbed the resident around the waist but was not able to stop the resident from falling forward onto her knees. The AP described the resident falling and stated after the resident fell onto her knees, the AP then lowered the resident's upper body into a laying position on the floor. The AP stated she did not use a gait belt while ambulating the resident to the bathroom the day of the residents fall, and never used a gait belt when transferring or ambulating the resident. The AP stated the resident was unsteady and needed a gait belt, however, she never used one because the resident refused to wear the gait belt. The AP stated she had never documented the resident's refusal to use a gait belt.

When interviewed, three unlicensed staff members stated the resident needed assistance from one staff with transfers and ambulation using a gait belt and a walker. The staff stated the resident did not refuse use of the gait belt. The staff stated the resident would suddenly become unsteady and weak when walking and suddenly would need to sit down. All three staff members stated the gait belt was in the resident's plan of care and they were instructed by administration and nursing to use a gait belt with the resident when the residents' plan of care was reviewed with all staff.

When interviewed a facility nursing staff stated when a resident was newly admitted to the facility the plan of care was reviewed with all staff during a house meeting. The nurse stated any resident who was unsteady when walking would require staff to use a gait belt when assisting with transfers or walking. The nurse stated if a resident had a physician order for staff assistance with transfers using a gait belt and a walker; it would be documented on the TAR.

The resident's record of death indicated the resident had a fall from standing height and identified the immediate cause of death was complications of a left hip fracture.

In conclusion, neglect was substantiated. The AP and facility were responsible for the maltreatment. The facility failed to update the resident's plan of care after a significant change

in health status. The AP knew the resident required use of a gait belt with transfers and ambulation but failed to use a gait belt. The resident fell and sustained a hip fracture.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Unable – deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided education to staff on falls, assessment, and maltreatment.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Louis County Attorney
Duluth City Attorney
St. Louis County Medical Examiner
MN Department of Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 26, 2022, the Minnesota Department of Health conducted a complaint investigation for HL25455001M, HL25455003M, HL25455002C, and HL25455004C at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 19 residents receiving services under the provider's Assisted Living Facility with Dementia Care. The following correction orders were issued for HL25455001M, HL25455003M, HL25455002C, and HL25455004C, tag identification 0620, 1690, 1910, 2360, and 3000.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of maltreatment for two of two residents (R1, and R2) reviewed for financial exploitation and neglect. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on June 29, 2017, with diagnoses including Lewy bodies syndrome. R1's Care Plan dated July 8, 2021, indicated R1 had alterations in self-preservation related to Parkinson's disease and dementia with Lewy bodies. Staff were directed to assist R1 with daily decision making, and R1's family would assist with medical decision making.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 2 Licensee's document titled, Internal Investigation, indicated on November 9, 2021, at 5:10 p.m., R1's family member (FM)-E reported to administrator (A)-F that R1's checking account had fraudulent charges from a bar and a liquor store. The charges were made using a cash application under unlicensed personnel (ULP)-A's name with the money from R1's account. MAARC Common Entry Point Intake Form, ID 393952612 dated November 11, 2021, indicated the licensee reported R1 was financially exploited by ULP-A; the report occurred greater than 24 hours after the licensee received notification of ULP-A's financial exploitation of R1. R2 was admitted to the facility on September 30, 2021, with diagnoses including dementia chronic kidney disease, hypertensive heart, mild cognitive impairment, metabolic encephalopathy. R2's undated Fall Risk Assessment indicated R2 was at a risk for falls due to a history of falls, incontinence, poor vision, balance problems while standing and walking, decreased motor coordination, and required assistive devices. R2's Fall Plan of Care dated September 30, 2021, identified R2 was at a risk for falls, and was able to walk short distances using a gait belt and a walker. R2's Vulnerability Assessment dated September 30, 2021, indicated R2 was at risk for abuse due to dependence on staff for mobility. R2's late entry incident note documented by ULP-B and dated November 16, 2021, at 11:30 a.m., indicated at 5:05 a.m. while assisting R2 to	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 3 ambulate to the bathroom, R2 stated "I can't walk", R2 then went limp and fell onto her knees. ULP-B documented lowering R2 to the floor by putting her arms around R2. The note indicated R2 had skin tears after the incident, so ULP-B applied dressings and called for assistance to get R2 off the floor. R2's progress note dated November 16, 2021, at 6:10 a.m., indicated R2 complained of pain and reported to ULP-H that ULP-B had "dropped her". The licensee document titled Internal Investigation, indicated ULP-B had not used a gait belt when ambulating R2 to the bathroom. R2 subsequently became unable to ambulate and fell onto her knees. The document's timeline of events indicated on November 16, 2021, at 1:00 p.m. R2's provider ordered x-ray's to be done, and at 4:00 p.m. the provider reported to the licensee R2 had fractured her hip. R2's progress note indicated on November 17, 2021, at 3:05 p.m. the resident died. MAARC Common Entry Point Intake Form, ID 394670842 indicated the licensee reported the incident on November 17, 2021, at 5:45 p.m., more than 24 hours following the incident, and after being notified of R2's hip fracture. On February 28, 2022, 12:05 p.m., Administrator-F indicated she was not aware of the need to immediately report then investigate allegations of abuse, neglect, or financial exploitation. License's policy titled, Vulnerable Adult and Abuse Prevention, dated January 2010, revised May 2020, indicated staff would make an internal	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	Continued From page 4 report, and the licensee had 24 hours to complete an internal investigation. The policy did not indicate the facility would immediately report suspected allegations of abuse, neglect, or financial exploitation to MAARC immediately. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 5 medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures consistent with current practice standards and guidelines to prevent medication discrepancies, and ensure safe accurate medication administration for one of one resident (R2) with records reviewed. The licensee's inconsistent medication management system had the potential to affect all residents receiving medication services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the facility on September 30, 2021, with diagnoses of dementia and mild cognitive impairment. R2's Service Agreement dated September 30, 2021, indicated R2 received medication	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 6 management services and required staff assistance with medication administration. R2's Care Plan dated October 1, 2021, indicated R2 had a self-care deficit and required staff assistance with medication administration. R2's hospice admission orders dated November 10, 2021, at 12:45 p.m., included morphine concentrate 20 milligrams (mg) per millimeter (ml) with instructions to staff to give 2 mg orally every four hours as needed (PRN) for shortness of breath. R2's Appointment Summary from a physician visit onsite dated November 16, 2021, included new orders to increase R2's morphine concentrate to 5 mg every six hours scheduled and hourly PRN for pain. R2's progress note dated November 16, 2021, at 4:30 p.m., and MAR indicated licensed practical nurse (LPN)-G documented the physician's order for R2's morphine 5 mg to be given every four hours scheduled, instead of every six hours scheduled and hourly PRN as directed by the November 16, 2021, physician orders. R2's progress note dated November 17, 2021, at 1:00 p.m. indicated LPN-G documented new orders were received to increase R2's morphine dose to 10 mg every four hours; and hourly PRN. R2's medication administration record (MAR) dated November 2021, lacked documentation of a start or stop date and time for each order frequency and dosage change of R2's morphine concentrate. R2's November 2021, MAR indicated each PRN and scheduled order remained active on the MAR with no	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 7 discontinuation. The same MAR listed the order for 5 mg morphine scheduled dose incorrectly every four hours instead of every six hours as prescribed. R2's MAR documentation showed the 5 mg PRN morphine dose and the 5 mg scheduled morphine dose crossed out with a single line drawn through it, and the 10 mg morphine dose written in above the previous orders. As a result, it was unclear if R2 received 5 mg or 10 mg of morphine with each dose administered according to the MAR. R2's progress note dated November 16, 2021, at 12:00 p.m., indicated ULP-H administered 2 mg of PRN morphine to R2, but did not document the morphine administration in R2's MAR. R2's progress note dated November 17, 2021, at 10:25 a.m., indicated ULP-H administered 5 mg of PRN morphine to R2, but ULP-H did not document the morphine administration in R2's MAR. R2's narcotic log and the MAR dated November 17, 2021, at 10:25 a.m., indicated ULP-H administered a 5 mg of PRN morphine to R2. R2's narcotic log dated November 17, 2021, at 11:45 a.m., indicated ULP-H administered 5 mg of scheduled morphine to R2. R2's November 2021 MAR and narcotic log dated November 17, 2021, at 12:20 p.m., the MAR and narcotic log indicated ULP-H administered 10 mg of morphine to R2, which was 35 minutes after the 11:45 a.m. morphine dose was administered. On February 22, 2022, 10:47 a.m., ULP-H stated when giving a narcotic pain medication she would assess the resident and make sure the	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 8 medication was given at the right time and the right dose according to the orders. ULP-H stated she did not recall any issues or confusion with R2's morphine orders. ULP-H stated the narcotic medication administration process included two staff members to sign off and check the narcotic order and ensure the medication was ok to give. ULP-H stated staff were supposed to document in the narcotic log and resident MAR for each dose administered. ULP-H stated staff would also document in a progress note for each PRN dose administered; however, sometimes documentation could be forgotten. On February 16, 2022, at 10:22 a.m., registered nurse (RN)-S stated R2 had uncontrolled pain with cares on November 17, 2021, around 12:00 p.m. RN-S stated she asked LPN-G when R2's received the last dose of morphine. RN-S stated LPN-G reported administering the last dose of morphine at 8:20 a.m. RN-S stated she was not aware of any other morphine administrations and requested R2 receive a 10 mg dose of morphine on November 17, at 12:20 p.m. for pain control. On February 28, 2022, at 10:16 a.m., RN-Q, who was also the clinical coordinator, stated when narcotics are logged into the facility from pharmacy, staff should look at the receipt and compare to the medication received dose, medication name, and expiration date. RN-Q stated the narcotic log index should include quantity of medication received (number of syringes received). RN-Q stated if an order dose or frequency was changed, she would expect the resident's MAR to show the previous order to be discontinued by highlighting the order in yellow, and the new order written in. The licensee's policy titled, Narcotic	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 9 Administration, revised January 19, 2018, instructed staff to review the resident MAR order. The policy indicated two staff members would count the medication and document logging narcotic medication as it comes into the building, including route and dose. The policy lacked instructions to staff about clear documentation, discontinuing orders, implementing new orders or order changes, including start and stop dates and space for clearly charting PRN documentation. No additional information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01690		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures consistent with current practice standards and guidelines to prevent potential diversion of controlled medications for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the facility on September 30, 2021, with diagnoses including dementia and metabolic encephalopathy. R2's Service Agreement dated September 30, 2021, indicated R2 received medication management services. The facility Narcotic Log Index with November 2021 information included columns to document the resident name and medication received date, time, and signature of the staff receiving the medication. The Narcotic Log Index included four controlled medications received for R2 and the quantity received into the facility for two of the four medications. The Narcotic Log Index indicated R2 received two morphine deliveries to the facility on November 10, 2021, and on	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 11 November 16, 2021. Only one of the morphine deliveries included documentation of the morphine concentration. Both the November 10 and 16, 2021, deliveries lacked documentation of the morphine quantity or volume received. The facility Destruction Log with November 2021 information indicated on November 22, 2021, R2's morphine, Ativan, and other medications were mixed with vinegar in a zip lock bag and thrown into the dumpster for destruction. On February 15, 2022, at 10:01 a.m., pharmacy director (PD)-T stated narcotics, including morphine concentrate, should not be destroyed in vinegar. PD-T stated morphine concentrate needed to be added to something non-ingestible and putting the drug in vinegar does not prevent ingestion. PD-T stated controlled substances should be disposed of separately from other medication. PD-T recommended Med Destroyer, RX destroyer, or Medisafe, and if no other means were available flushing, a scheduled II drug was acceptable. On February 28, 2022, at 10:16 a.m. registered nurse (RN)-Q, who was also the clinical coordinator, stated the current facility process to destroy discontinued medications was to add the medication to vinegar in a zip lock bag and then discard in the trash. RN-Q indicated the facility used no other process to destroy medications to prevent ingestion of narcotics like liquid morphine. The pharmacy provided document received, February 15, 2022, by FDA.gov titled, "Medicines recommended for disposal by flushing listed medications by active ingredient," updated May 2019, included morphine and indicated morphine	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 12 may be harmful or fatal with just one dose by someone other than the person for whom the morphine was prescribed and recommended destruction of the medication by flushing unused medication down the sink or toilet to prevent ingestion. Licensee's policy titled, "Destruction or Removal of Medication," revised November 2017, indicated two staff members would witness and sign off on medication destruction, and instructed staff to place the medication in a baggies and pour vinegar over the top of the medication. The policy instructed staff to then seal the baggie and place it inside a second baggie to then toss in the garbage. The policy did not provide another process for destruction of controlled medications. No additional information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01910		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the licensee failed to ensure two of two residents (R1, R2) reviewed were free from maltreatment. R1 was financially exploited, and R2 was neglected. Findings include:	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02360	Continued From page 13 On January 26, 2022, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred for R1 (HL25455001M), and an individual staff person was responsible for the maltreatment in connection with incidents which occurred at the facility; and neglect occurred for R2 (HL25455003M), and the facility and an individual staff person(s) were responsible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 14 (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an allegation of maltreatment for two of two residents (R1, and R2) reviewed for financial exploitation and neglect. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 15 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on June 29, 2017, with diagnoses including Lewy bodies syndrome. R1's Care Plan dated July 8, 2021, indicated R1 had alterations in self-preservation related to Parkinson's disease and dementia with Lewy bodies. Staff were directed to assist R1 with daily decision making, and R1's family would assist with medical decision making. Licensee's document titled, Internal Investigation, indicated on November 9, 2021, at 5:10 p.m., R1's family member (FM)-E reported to administrator (A)-F that R1's checking account had fraudulent charges from a bar and a liquor store. The charges were made using a cash application under unlicensed personnel (ULP)-A's name with the money from R1's account. MAARC Common Entry Point Intake Form, ID 393952612 dated November 11, 2021, indicated the licensee reported R1 was financially exploited by ULP-A; the report occurred greater than 24 hours after the licensee received notification of ULP-A's financial exploitation of R1. R2 was admitted to the facility on September 30, 2021, with diagnoses including dementia chronic kidney disease, hypertensive heart, mild cognitive impairment, metabolic encephalopathy. R2's undated Fall Risk Assessment indicated R2 was at a risk for falls due to a history of falls,	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 16 incontinence, poor vision, balance problems while standing and walking, decreased motor coordination, and required assistive devices. R2's Fall Plan of Care dated September 30, 2021, identified R2 was at a risk for falls, and was able to walk short distances using a gait belt and a walker. R2's Vulnerability Assessment dated September 30, 2021, indicated R2 was at risk for abuse due to dependence on staff for mobility. R2's late entry incident note documented by ULP-B and dated November 16, 2021, at 11:30 a.m., indicated at 5:05 a.m. while assisting R2 to ambulate to the bathroom, R2 stated "I can't walk", R2 then went limp and fell onto her knees. ULP-B documented lowering R2 to the floor by putting her arms around R2. The note indicated R2 had skin tears after the incident, so ULP-B applied dressings and called for assistance to get R2 off the floor. R2's progress note dated November 16, 2021, at 6:10 a.m., indicated R2 complained of pain and reported to ULP-H that ULP-B had "dropped her". The licensee document titled Internal Investigation, indicated ULP-B had not used a gait belt when ambulating R2 to the bathroom. R2 subsequently became unable to ambulate and fell onto her knees. The document's timeline of events indicated on November 16, 2021, at 1:00 p.m. R2's provider ordered x-ray's to be done, and at 4:00 p.m. the provider reported to the licensee R2 had fractured her hip. R2's progress note indicated on November 17, 2021, at 3:05 p.m. the resident died.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25455	A. BUILDING: _____ B. WING _____	C 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HAVEN INC	3042 MORRIS THOMAS ROAD DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 17 MAARC Common Entry Point Intake Form, ID 394670842 indicated the licensee reported the incident on November 17, 2021, at 5:45 p.m., more than 24 hours following the incident, and after being notified of R2's hip fracture. On February 28, 2022, 12:05 p.m., Administrator-F indicated she was not aware of the need to immediately report then investigate allegations of abuse, neglect, or financial exploitation. License's policy titled, Vulnerable Adult and Abuse Prevention, dated January 2010, revised May 2020, indicated staff would make an internal report, and the licensee had 24 hours to complete an internal investigation. The policy did not indicate the facility would immediately report suspected allegations of abuse, neglect, or financial exploitation to MAARC immediately. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		